

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please submit the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

1  
FOR STATE  
HEALTH DEPT.

(M)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12428 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
12407											
1. PLACE OF DEATH a. COUNTY <u>CAROLINE</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>DENTON</u> c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>DENTON</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>LINDA ARIABELLA CARLISLE</u> First Middle Last 4. DATE OF DEATH <u>NOV 17, 1960</u> Month Day Year						5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>SEPT. 8, 1890</u> 9. AGE (In years last birthday) <u>70</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>home</u> 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>						13. FATHER'S NAME <u>Samuel Anthony</u> 14. MOTHER'S MAIDEN NAME <u>Josephine Truitt</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <u>J</u> 17. INFORMANT <u>John Carlisle, Greenboro Rd.</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary Heart Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>420.1</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>14 Hrs.</u>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>11-17-60</u> 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Denton Caroline Md</u> 20f. (City or town) (County) (State)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Denton Caroline</u>											
ACTUAL SIGNATURE <u>Dawson T. George</u> M.D. EXAMINER'S NAME (Type) <u>Dawson T. George MD</u> DATE SIGNED <u>11-17-60</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>Nov. 20, 1960</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Denton</u> 22d. LOCATION (City, town, or county) (State) <u>Denton, Md</u>				23. FUNERAL DIRECTOR <u>George Monahan</u> ADDRESS <u>Denton, Md</u> 24a. REC'D BY REGISTRAR <u>NOV 22 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

1845

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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12430

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Federalsburg</b>			c. LENGTH OF STAY IN 1b <b>Full Life</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Federalsburg</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>L.</b> Middle <b>Claude</b> Last <b>Covey</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>1</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 16, 1904</b>		9. AGE (In years last birthday) <b>56</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housepainter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Painter</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Luther H. Covey</b>				14. MOTHER'S MAIDEN NAME <b>Nancy Nichols</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>220-10-9985</b>		INFORMANT <b>Mrs. Virginia Covey</b>		Address <b>Federalsburg</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>chronic myo carditis</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 1, 1960</b> to <b>Nov 1, 1960</b> , that I last saw the deceased alive on <b>Nov 1, 1960</b> , and that death occurred at <b>6:30 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>F. M. Anderson</b> M.D.				ADDRESS (Street, city or town, state) <b>Federalsburg, Md.</b> DATE SIGNED <b>11/2/60</b>			
PHYSICIAN'S NAME (Type) <b>F. M. Anderson.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 4, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest</b>		22d. LOCATION (City, town, or county) (State) <b>Federalsburg, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harvey Williams</b>				ADDRESS <b>Federalsburg, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 7 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CHIEF OF POLICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12435

## CERTIFICATE OF DEATH

12409

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>CAROLINE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL GREENS BORO</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>DENTON</u>	
3. NAME OF DECEASED (Type or print) <u>OCTAVIA FLAMER</u>		4. DATE OF DEATH <u>NOV 27 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 27, 1866</u>
9. AGE (In years last birthday) <u>94</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>domestic servant</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTH PLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Wayman</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Wyatt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Lizzie Brown Denton</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocarditis, Senile</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Several yrs.</u> <u>Several mths.</u> <u>Several yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 19, 1960</u> , to <u>Nov 19, 1960</u> , that I last saw the deceased alive on <u>Nov 19, 1960</u> , and that death occurred at <u>9 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dawson D. George</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>11-29-60</u>	
PHYSICIAN'S NAME (Type) <u>Dawson D. George M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. M. Moulton</u>		ADDRESS	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <u>DEC 5 '60</u>		<u>C. H. L. Kline</u>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED <i>John A. Smith</i></p>		<p>2. SEX <i>Male</i></p>	
<p>3. AGE <i>45</i></p>		<p>4. DATE OF BIRTH <i>Jan 15, 1900</i></p>	
<p>5. PLACE OF BIRTH <i>Baltimore, Md.</i></p>		<p>6. OCCUPATION <i>Engineer</i></p>	
<p>7. MARITAL STATUS <i>Married</i></p>		<p>8. DATE OF MARRIAGE <i>June 10, 1925</i></p>	
<p>9. NAME OF SPOUSE <i>John A. Smith</i></p>		<p>10. DATE OF DEATH <i>Jan 10, 1945</i></p>	
<p>11. PLACE OF DEATH <i>Home</i></p>		<p>12. CAUSE OF DEATH <i>Heart Disease</i></p>	
<p>13. MEDICAL HISTORY <i>None</i></p>		<p>14. SURVIVAL <i>Yes</i></p>	
<p>15. SIGNATURE OF DECEASED <i>John A. Smith</i></p>		<p>16. SIGNATURE OF WITNESS <i>John A. Smith</i></p>	
<p>17. SIGNATURE OF PHYSICIAN <i>John A. Smith</i></p>		<p>18. SIGNATURE OF CLERK <i>John A. Smith</i></p>	
<p>19. SIGNATURE OF DECEASED <i>John A. Smith</i></p>		<p>20. SIGNATURE OF WITNESS <i>John A. Smith</i></p>	
<p>21. SIGNATURE OF PHYSICIAN <i>John A. Smith</i></p>		<p>22. SIGNATURE OF CLERK <i>John A. Smith</i></p>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 9/59

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12432  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12410

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greensboro</b>		c. LENGTH OF STAY IN 1b <b>14 Yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>None</b>		d. STREET ADDRESS <b>1 Sunset Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Lillian</b> Middle <b>Virginia</b> Last <b>Ginn</b>		4. DATE OF DEATH Month <b>11</b> Day <b>21</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>3-20-1898</b>
9. AGE (In years last birthday) <b>62</b> yrs.		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>21</b> Hours <b>19</b> Min.	11. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George H. Ginn</b>		14. MOTHER'S MAIDEN NAME <b>Rosa Goldsborough</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Miss Mildred Ginn Greensboro, Maryland</b>	
17. INFORMANT <b>Miss Mildred Ginn Greensboro, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Dis.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Rheumatoid Arthritis</b>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 20, 1960</b> to <b>Nov. 21, 1960</b> , that (I) (we) last saw the deceased alive on <b>Nov. 21, 1960</b> , and that death occurred at <b>1:30 P.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Charles H. Stonesifer</b>		22b. DATE SIGNED <b>11/22/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Charles H. Stonesifer, M.D.</b>		22d. ADDRESS <b>Greensboro, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-23-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Townsend</b>		23d. LOCATION (City, town, or county) (State) <b>Townsend, Delaware</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. E. Boulaire</b>		24. ADDRESS <b>Greensboro, Md.</b>	
25a. REC'D BY REGISTRAR DATE <b>NOV 28 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. House</b>	

1241

CENTRAL OFFICE

1241







# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1911

1911

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		JAN 15 1875		BALTIMORE, MD	
RESIDENCE		OCCUPATION		CAUSE OF DEATH	
BALTIMORE, MD		LABORER		HEART DISEASE	
DATE OF DEATH		PLACE OF DEATH		MANNER OF DEATH	
JAN 25 1911		BALTIMORE, MD		NATURAL	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		OFFICIAL USE	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 25 1911		JAN 25 1911		JAN 25 1911	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12412

12436

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Ridgely</b>				c. LENGTH OF STAY IN 1b <b>1 yr.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Ridgely</b>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>None</b>				d. STREET ADDRESS <b>1</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Albert</b> Middle <b>Morris</b> Last <b>Murray</b>				4. DATE OF DEATH Month <b>November</b> Day <b>2</b> Year <b>1960</b>											
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 2, 1895</b>		9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Day Laborer</b>				11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Raymond Murray</b>				Address <b>Ridgely, Maryland</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 5, 1959</b> to <b>Nov. 2, 1960</b> , that (I) (we) last saw the deceased alive on <b>Nov. 2, 1960</b> , and that death occurred at <b>9:30 AM</b> , from the causes and on the date stated above.															
22a. SIGNATURE <b>Charles H. Stonesifer</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <b>11-3-60</b>											
22c. PHYSICIAN'S NAME (Type) <b>Charles H. Stonesifer, M.D.</b>				22d. ADDRESS <b>Greensboro, Maryland</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>11-5-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Boonsboro</b>		23d. LOCATION (City, town, or county) (State) <b>Rural Ridgely, Maryland</b>							
24. FUNERAL DIRECTOR'S SIGNATURE <b>John E. Boula's Jr.</b>				ADDRESS <b>Greensboro, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>NOV 7 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>					

12430

CERTIFICATE OF DEATH

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS

1915

1

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
12437 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>CAROLINE</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL DENTON</u> c. LENGTH OF STAY IN 1b <u>50 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL DENTON</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HARRY JONATHAN MURPHY</u> First Middle Last		4. DATE OF DEATH <u>Nov. 15 1960</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR. 13, 1895</u> 9. AGE (In years last birthday) <u>65</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farm owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM MURPHY</u>		14. MOTHER'S MAIDEN NAME <u>LIDA NOBLE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes WWI</u>		16. SOCIAL SECURITY NO. <u>919-1</u>	
17. INFORMANT <u>Ezra Harry Murphy Denton, husband</u> Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Guns shot wound to R. chest</u> DUE TO (b) <u>Immediate</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Carrying loaded gun on tractor, accidentally hit</u>	
20c. TIME OF INJURY Month, Day, Year <u>11-15-1960</u> Hour a.m. <u>11-15</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Farm</u>		20f. (City or town) (County) (State) <u>Denton, Caroline, Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Dawson D. George</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Dawson D. George M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>NOV 19, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Concord</u>		22d. LOCATION (City, town, or country) (State) <u>Concord, Md.</u>	
23. FUNERAL DIRECTOR <u>J. Virgil Moore &amp; Son Denton, Md.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>NOV 22 '60</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	



MASSACHUSETTS DEPARTMENT OF HEALTH

15485

THE STATE  
HEALTH BOARD



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Handwritten text, likely a medical report or certificate, including names and dates. The text is mostly illegible due to fading and bleed-through.



TO FURNER DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

TO MEDICAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FURNER DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12414

12431

1. PLACE OF DEATH a. COUNTY <b>CAROLINE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>DELAWARE</b> b. COUNTY <b>KENT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FEDERALSBURG</b>		c. LENGTH OF STAY IN 1b <b>2 MONS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>BROOKLYN AVE</b>		d. STREET ADDRESS <b>R.F.D. 46X-3</b>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>EMILY</b> Last <b>PRITCHETT</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>18</b> Year <b>1960</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 27, 1899</b>
9. AGE (In years lost birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>21</b> Hours <b></b> Min. <b></b>	11. IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DAY LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CANNERY</b>	
11. BIRTHPLACE (State or foreign country) <b>SUSSEX COUNTY, DEL.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>ANDREW CANNON</b>		14. MOTHER'S MAIDEN NAME <b>LILY PINCKENS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>41-0419080</b>	
17. INFORMANT <b>IDA ROBERTA BRIGGS</b>		Address <b>FEDERALSBURG, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>General Metastasis (Brain-Liver)</b> DUE TO <b>Primary Carcinoma Left Ovary.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>involving - uterus - liver &amp; brain</b> (c) <b></b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>This patient was only seen twice by undersigned</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 25, 1960</b> to <b>Nov 18, 1960</b> , that (I) (we) last saw the deceased alive on <b>Nov 13, 1960</b> , and that death occurred at <b>11:15 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>W. E. Gannon</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE <b>11-21-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. E. Gannon M.D.</b>		22d. ADDRESS <b>Federalsburg Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>Nov. 21, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>FEDERAL HILL</b>		23d. LOCATION (City, town, or county) (State) <b>FEDERALSBURG MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. J. Frampton &amp; Son</b>		ADDRESS <b>Federalsburg, Md.</b>	
25a. REC'D BY REGISTRAR <b>NOV 28 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Fries</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 should be filed with the funeral director. Pages 2 and 3 should be filed with the funeral director. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
12434  
CERTIFICATE OF DEATH

12415

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greensboro</b>		c. LENGTH OF STAY IN 1b <b>1 yr.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cahall Rest Home</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greensboro</b>	
f. STREET ADDRESS <b>1 Sunset Ave.</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>Seward</b> Last <b>Seward</b>		4. DATE OF DEATH Month <b>November</b> Day <b>1</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 8, 1876</b>
9. AGE (In years last birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
13. BIRTHPLACE (State or foreign country) <b>Maryland</b>		14. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. FATHER'S NAME <b>Unknown</b>		16. MOTHER'S MAIDEN NAME <b>Unknown</b>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		18. SOCIAL SECURITY NO. <b>None</b>	
19. INFORMANT <b>Mrs. Carrie Dabson</b>		Address <b>Greensboro, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Nephritis</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Myocarditis</b> DUE TO (c) <b>Generalized Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Bronchitis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 15, 1958</b> to <b>Nov. 1, 1960</b> , that (I) (we) last saw the deceased alive on <b>Oct. 31, 1960</b> , and that death occurred at <b>4 A.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Charles H. Storesifer</b>		22b. DATE SIGNED <b>11/1/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Charles H. Storesifer, M.D.</b>		22d. ADDRESS <b>Greensboro, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-3-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Greensboro</b>		23d. LOCATION (City, town, or county) (State) <b>Greensboro, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John E. Boulaia, Jr.</b>		ADDRESS <b>Greensboro, Md.</b>	
25a. REC'D BY REGISTRAR <b>NOV 3 1960</b>		25b. REGISTRAR'S SIGNATURE <b>...</b>	

1941

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 9/59

12438										12416									
MARYLAND STATE DEPARTMENT OF HEALTH										DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH																			
1. PLACE OF DEATH a. COUNTY <b>Caroline</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Goldsboro</b>					c. LENGTH OF STAY IN 1b <b>60 Yrs.</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Goldsboro</b>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>None</b>					d. STREET ADDRESS <b>None</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>Noble</b> First <b>J.</b> Middle <b>Shively</b> Last					4. DATE OF DEATH Month <b>11</b> Day <b>16</b> Year <b>1960</b>														
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-10-1892</b>		9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Contractor-BUILDER</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>Carpenter</b>					11. BIRTHPLACE (State or foreign country) <b>Maryland</b>					12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>James W. Shively</b>					14. MOTHER'S MAIDEN NAME <b>Lydia Dennison</b>														
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. <b>218-20-4352</b>					17. INFORMANT <b>Mae B. Shively</b> Address <b>Goldsboro, Maryland</b>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CACHEXIA FROM MULTIPLE METASTASES</b> DUE TO <b>1777X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CARCINOMA OF PROSTATE</b> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <b>2 WEEKS</b> <b>1 YEAR</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>10/13</b> 19 <b>59</b> to <b>11/16</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>11/15</b> 19 <b>60</b> , and that death occurred at <b>P.M.</b> from the causes and on the date stated above.																			
22a. SIGNATURE <b>Robert H. Waight, M.D.</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED <b>11/18/60</b>									
22c. PHYSICIAN'S NAME (Type) <b>ROBERT H. WAIGHT, M.D.</b>					22d. ADDRESS <b>GREENSBORO, MARYLAND</b>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					23b. DATE THEREOF <b>11-19-60</b>					23c. NAME OF CEMETERY OR CREMATORY <b>Greensboro</b>					23d. LOCATION (City, town, or county) (State) <b>Greensboro, Maryland</b>				
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. E. Borelais</b>					ADDRESS <b>Greensboro, Md.</b>					25a. REC'D BY REGISTRAR <b>NOV 21 '60</b>					25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>				

1951

CERTIFICATE OF DEATH

15438

Blank certificate form with faint lines and text, including fields for name, date, and cause of death.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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12439

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12417

1. PLACE OF DEATH o. COUNTY <u>Caroline</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Ind.</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural - preston</u>				c. LENGTH OF STAY IN 1b <u>10 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____				d. STREET ADDRESS <u>1 Rural</u>			
3. NAME OF DECEASED (Type or print) First <u>Carrie</u> Middle <u>Washington</u> Last _____				4. DATE OF DEATH Month <u>11</u> Day <u>24</u> Year <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-15-90</u>	9. AGE (In years lost birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Washington</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. <u>213-28-5781</u>		17. INFORMANT <u>Mary L. Sharp</u> Address <u>Route 2 Box 182 preston, ind.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute left ventricular failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Arterio insufficiency &amp; stenosis</u> DUE TO (c) <u>Arteriosclerotic heart disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>8 yrs</u> <u>10-15 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____					
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 1952</u> to <u>Nov. 24</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Nov. 15</u> 19 <u>60</u> and that death occurred at <u>7 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Stacy B. Plummer</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>11/28/60</u>			
22c. PHYSICIAN'S NAME (Type) <u>DR. H-B. Plummer</u>				22d. ADDRESS <u>Preston Ind.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-29-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Harmony Cem.</u>		23d. LOCATION (City, town, or county) <u>Preston, Ind.</u> (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>James B. LaBriel</u> ADDRESS <u>Easton, Ind.</u>				25a. REC'D BY REGISTRAR DATE <u>DEC 5 '60</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Frank</u>	

15413

CERTIFICATE OF DEATH

15413

*[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words like "Name", "Age", "Sex", "Race", "Date of Birth", "Date of Death", "Cause of Death", "Place of Death", "Signature", and "Witness" are faintly visible.]*

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please file the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12421 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
12418											
1. PLACE OF DEATH a. COUNTY <b>CAROLINE</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>DENTON</b> c. LENGTH OF STAY IN 1b <b>1 hr</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CAROLINE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL GREENSBORO</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>JOHN WITBAK</b>						4. DATE OF DEATH Month <b>NOV.</b> Day <b>29</b> Year <b>1960</b>					
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JUNE 9, 1904</b>		9. AGE (In years last birthday) <b>56</b> yrs.		IF UNDER 1 YEAR Months <b>5</b> Days <b>6</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DRUGHTSMAN</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>LUMBER</b>				11. BIRTHPLACE (State or foreign country) <b>Penn</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>KARL WITBAK</b>						14. MOTHER'S MAIDEN NAME <b>unknown</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>						16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>bro John Witbak Greensboro, Md.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> <b>Coronary Heart Disease</b> DUE TO (b) <b>Coronary Occlusion</b> DUE TO (c) <b>Immediate</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Several yrs.</b>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Dawson O. George</b>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED <b>11-29-60</b>		
EXAMINER'S NAME (Type) <b>Dawson O. George M.D.</b>						M.D. <b>DEPUTY MEDICAL EXAMINER</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>Dec 1, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Denton</b>		22d. LOCATION (City, town, or country) (State) <b>Denton Md.</b>			
23. FUNERAL DIRECTOR <b>Integrity Moore Sons</b>						ADDRESS <b>Denton Md.</b>		24a. REC'D BY REGISTRAR <b>DEC 5 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>	

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1891

1845 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1891

State of New York  
County of ...  
I, the undersigned, a duly qualified Medical Examiner, do hereby certify that on the ... day of ... 1891, at ...  
I examined the body of ... deceased, and found the cause of death to be ...

Witness my hand and seal this ... day of ... 1891.  
Medical Examiner

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Subscribed and sworn to before me this ... day of ... 1891.  
Notary Public

Attest my hand and seal this ... day of ... 1891.  
Notary Public